keith davis

continued program participation.

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

02/23/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155786		(X2) MULTIPLE CO A. BUILDING B. WING			ED	
	PROVIDER OR SUPPLIER		10312 A	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
E 0000						
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0000			
	Allisonville Meadov with Emergency Pre Medicare and Medic and Suppliers, 42 C	12466 155786 014060 Preparedness survey, ws was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.  certified beds. At the time of us was 134.				
K 0000						
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000			
	Survey Date: 02/08	/24				
	Facility Number: 0 Provider Number: 1 AIM Number: 2010	155786				
		Code survey, Allisonville d not in compliance with				
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(2	K6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W39W21 Facility ID: 012466 If continuation sheet Page 1 of 20

Senior executive director

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155786		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/08/2024		
	ROVIDER OR SUPPLIER		10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety From Fi National Fire Protect Life Safety Code (L Health Care Occupa This one story facility Type V (111) const The facility has a find detection in the corn the corridor. The fa hard wired to the fin	articipation , 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  The sty was determined to be of ruction and fully sprinklered. The alarm system with smoke ridor and in all areas open to fine alarm system installed in all forms. The facility has a had a census of 134 at the			
	All areas where the	-			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirem				
	failed to ensure 1 of area was free of cordebris. LSC 19.1.1 facilities shall be demaintained and ope possibility of a fire evacuation of occup	ation and interview, the facility I electric range in the therapy inbustible material and other I attest all health care resigned, constructed, rated to minimize the emergency requiring the mants. This deficient practice I residents and staff in the	K 0100	We respectfully request desk review in this matter. Thank ye for your consideration. what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? - no reside were affected by this alleged deficient practice the cookie in question was immediately removed. lint removed from the floor, walls and ceiling in que	1) pe ents py the ents p box
	_	ons and interview during a		in the laundry area. 2) how wi identify other residents having	ll you

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 2 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155786	A. BU	UILDING	onstruction 01	(X3) DATE COMPL <b>02/08</b> /	ETED
			10312 A	ALLISONVILLE RD		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
tour of the facility of on 02/08/24 between electric range in the supplied to the applied electric burners a part contact with the burners aforementioned appethe condition and residurer.  The findings were resulted burner.  The findings were resulted burner.  The findings were resulted burner.  2. Based on observation and states all health carding constructed, maintathe possibility of a resulted burner.  Based on observation of occupation of occupation of occupation of the facility of on 02/08/24 between floor, walls, ceiling the dryers in the law covered with dryer time of observation substantial amount behind the dryers at need to be cleaned.  The findings were resulted to the facility of th	with the Maintenance Director on 11:20 a.m. and 1:30 p.m., the otherapy area, with power iance, had placed on the aper cookie box in direct mers failing to minimize the emergency relating to the oliance. The MD acknowledged emoved the box from the  reviewed with the Maintenance of discovery and again with Executive Director during the  ation and interview, the facility of 1 laundry area dryer rooms other debris. LSC 19.1.1.3.1 of facilities shall be designed, ined and operated to minimize fire emergency requiring the oants. This deficient practice laundry staff.  ons and interview during a with the Maintenance Director on 11:20 a.m. and 1:30 p.m., the of and dryers in the room behind ondry area were substantially lint. Based on interview at the of the MD agreed there was a of dryer lint within the room ond further said the area would		TAG	potential to be affected by the same deficient practice and w corrective action will be taken' all residents have the same potential to be affected by this alleged deficient practice the cookie box in question was immediately removed. the lint question has been removed fr the floor, walls and ceiling in the floor, walls and ceiling in the laundry area. IDT, therapy, maintenance and laundry educated by the senior Execu Director by 2/24/24 on combustible material on the reand lint in the laundry room. 3 what measures will be put into place or what systemic changyou will make to ensure that the deficient practice does not receive the cookie box in question was removed immediately. the lint question has been removed from the floor, walls and ceiling in the laundry area IDT, therapy, maintenance and laundry educated by the senior E.D. be 2/24/24 combustible material of the range and lint in the laund room Maintenance/designed conduct audits to ensure compliance (see attachment of 4.) how the corrective action (see monitored to ensure the deficient practice will not recur,i.e., what quality assurant program will be put into place; ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurant program will be put into place; ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurant program will be put into place; ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurant program will be put into place; ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurant program will be put into place; ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recurs.	hat ? - in omne tive inge ) es in omne y on ry e to c) ) will nce - ored	DATE
Director at the time	of discovery and again with			via facility QAPI program, with	l	
	SUMMARY (EACH DEFICIENT REGULATORY OF tour of the facility of the supplied to the applied to a fire aforementioned applied to applied to the condition and results and the time the MD and Senior exit conference.  2. Based on observational facility of a sevacuation of occupant to the possibility of a sevacuation of occupant to the facility of the facili	DENTIFICATION NUMBER 155786  ROVIDER OR SUPPLIER  IVILLE MEADOWS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the electric range in the therapy area, with power supplied to the appliance, had placed on the electric burners a paper cookie box in direct contact with the burners failing to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD acknowledged the condition and removed the box from the burner.  The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference.  2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff.  Findings include:  Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, ceiling, and dryers in the room behind the dryers in the laundry area were substantially covered with dryer lint. Based on interview at the time of observation, the MD agreed there was a substantial amount of dryer lint within the room behind the dryers and further said the area would	PROVIDER OR SUPPLIER  NULLE MEADOWS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the electric range in the therapy area, with power supplied to the appliance, had placed on the electric burners a paper cookie box in direct contact with the burners failing to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD acknowledged the condition and removed the box from the burner.  The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference.  2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff.  Findings include:  Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, ceiling, and dryers in the room behind the dryers in the laundry area were substantially covered with dryer lint. Based on interview at the time of observation, the MD agreed there was a substantial amount of dryer lint within the room behind the dryers and further said the area would need to be cleaned.  The findings were reviewed with the Maintenance	STREET 10312 / FISHER  WILLE MEADOWS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TOUR of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the electric range in the therapy area, with power supplied to the appliance, had placed on the electric burners a paper cookie box in direct contact with the burners failing to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD acknowledged the condition and removed the box from the burner.  The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference.  2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff.  Findings include:  Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, ceiling, and dryers in the room behind the dryers in the laundry area were substantially covered with dryer lint. Based on interview at the time of observation, the MD agreed there was a substantial amount of dryer lint within the room behind the dryers and further said the area would need to be cleaned.  The findings were reviewed with the Maintenance	DENTIFICATION NUMBER 155786  ROVIDER OR SUPPLIER  WILLE MEADOWS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR IS CEIDENTEYMON FOR MINE DEFICIENCY ON 150 BENEFITY MORE THE PRECEDED BY PULL REGULATORY OR IS CEIDENTEYMON FORMATION TO OR 2008/24 between 11:20 a.m. and 1:30 p.m., the electric burners a paper cookie box in direct contact with the burners falling to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD acknowledged the condition and removed the box from the burner.  The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference.  2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff.  Findings include:  Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, aciling, and dryers in the room behind the dryers and further said the area would need to be cleaned.  The findings were reviewed with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, aciling, and dryers in the room behind the dryers and further said the area would need to be cleaned.  The findings were reviewed with the Maintenance on the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, aciling, and dryers in the room behind the dryers and further said the area would need to be cleaned.  The findings were reviewed with the Maintenance on the facility with the Maintenance of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. a	A BUILDING DATE OF COMPLOYER TO THE TOTAL TO THE THE TABLE TO THE TABLE THE TABL

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 3 of 20

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155786  X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  D1  B. WING		(X3) DATE : COMPL 02/08/	ETED			
	PROVIDER OR SUPPLIER			10312 A	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the MD and Senior exit conference.  3.1-19(b)	Executive Director during the			meetings being held every othmonth, and is overseen by the Executive Director CQI tool identified as life safety poc (se attachment C) will be complete weekly x 4 weeks, monthly tim 6 months, and quarterly thereauntil compliance is achieved threshold of 100% is not met, a action plan will be developed to ensure compliance. 5) By what date the systemic changes will completed; completion date: 2/24/24	e ed es after If an o	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities						
	failed to ensure staff switch for 1 of 1 cool LSC 19.3.2.5.4 state residential or commis used to prepare m shall be permitted, pfacility complies with conditions:  (1) The space contains not a sleeping room (2) The space contains not a sleeping room (2) The space contains and 19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, if acility that deactives	ining the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. as of 19.3.2.5.3(1) through (10) A switch meeting all of the	K 03	324	we respectfully request desk review in regards to this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; - no reside were affected by this alleged deficient practice range is powered off and staff have account to power source.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; -	on.  ee nts y the nts cess	02/24/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 4 of 20

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155786	B. W	NG		02/08/	/2024
				CTREET	ADDRESS STEW STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
A	I) /II   E NAEA DOLA/O				ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	G DEFICIENCY)		DATE
	or range whenever	the kitchen is not under staff			All residents/staff have th	е	
	supervision.				same potential to be affected b	ογ	
	This deficient pract	ice could affect up to 10			this alleged deficient practice.	-	
	residents and staff i	-			range is powered off and staff		
					access to power source there		
	Findings include:				idt and maintenance staff were		
					educated by the Senior Execu		
	Based on observation	ons and interview during a			Director by 2/24/24 on location		
		with the Maintenance Director			power source to therapy range		
	-	en 11:20 a.m. and 1:30 p.m., there			need of power off when not in		
		ge in the therapy area that was			,		
	_	t in use. The Maintenance					
	_	if staff knew how to deactivate					
		in use and he indicated that					
	-	ove the appliance in a cabinet.					
		**					
	The findings were r	reviewed with the Maintenance					
	_	of discovery and again with					
		Executive Director during the			What measures will be put into	)	
	exit conference.	C			place or what systemic change		
					will be made to ensure that the		
	3.1-19(b)				deficient practice does not rec		
					- range powered off and staff		
					access to power source		
					education provided to idt, ther	ару	
					staff and maintenance by the	. ,	
					Senior Executive Director by		
					2/24/24 on location of power		
					source and need to power off	when	
					not in use		
					Maintenance/designee to audi	t to	
					ensure range powered off whe		
					in use. (see attachment C).		
					How the corrective action(s) w	ill be	
					monitored to ensure the deficie		
					practice will not recur, what qu	ality	
					l		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 5 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155786	A. BUILDING  B. WING	<u> </u>	
	ROVIDER OR SUPPLIER		10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
K 0353	NEPA 101			assurance program will be put place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as life safety poc audits (see attachm C) will be completed weekly x weeks, monthly times 6 month and quarterly thereafter until compliance is achieved. If Threshold of 100% is r met, an action plan will be developed to ensure complian. By what date the systemic changes will be completed; Completion date: 2/24/24	held held hent 4 ns, not
K 0353 SS=E Bldg. 01	Based on observation failed to ensure spring were not loaded or on accordance with ledition, at 5.2.1.1.1 of leakage; shall be materials, paint, and be installed in the coup-right, pendent, or 5.2.1.1.2 any sprink the following shall be Corrosion (3) Physical the glass bulb heat results.	mand interview, the facility inkler heads behind the dryers covered with foreign material LSC 9.7.5. NFPA 25, 2011 sprinklers shall not show signs free of corrosion, foreign physical damage; and shall briect orientation (e.g., is sidewall). Furthermore, at the that shows signs of any of the replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in esponsive element (5) gunless painted by the	K 0353	we respectfully request desk review in this matter. Thank yo for your consideration.  What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; - no reside were affected by this alleged deficient practice sprinkler he in laundry area cleaned/repair accordingly and sprinkler head not loaded or covered with force	pe ints y the ints ead ed d is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 6 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155786	A. BUILDING <u>01</u>		COMPLETED 02/08/2024	
	PROVIDER OR SUPPLIER		10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	could affect staff ma	rer. This deficient practice ainly in the laundry area.		material.		
	tour of the facility won 02/08/24 betwee sprinkler head in the coved in lint or show.  The findings were redirector at the time	ons and interview during a with the Maintenance Director in 11:20 a.m. and 1:30 p.m., the eroom behind the dryers was wed signs of loading.  eviewed with the Maintenance of discovery and again with Executive Director during the		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;  All residents/staff have the same potential to be affected this alleged deficient practice, sprinkler head in laundry areast cleaned/repaired accordingly sprinkler head is not loaded of covered with foreign material. IDT/ Maintenance personnel educated by the Senior Exect Director by 2/24/24 on the maintenance of sprinkler head (see attachment A).	ne by - and r -	
				What measures will be put interplace or what systemic chang will be made to ensure that the deficient practice does not reconstruction of the control of the	es e cur; rea and r - vas	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 7 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

		(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIE		10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD ERS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				sprinkler head maintenance. ( attachment A) - Maintenance audit sprinkler heads to keep free from loading and free froi foreign material. ( see attachr C)	to them m
				How the corrective action(s) version monitored to ensure the deficing practice will not recur, what quassurance program will be purplace;  Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director.  CQI tool identified as lifted safety audits (see attachment will be completed weekly x 4 weeks, monthly times 6 monthly and quarterly thereafter until compliance is achieved.  If Threshold of 100% is	ient uality t into  n i held  CC)
				met, an action plan will be developed to ensure compliar  By what date the systemic changes will be completed;  Completion date: 2/24/2	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors	on and interview the facility	V 02/2	we repositfully request deals	02/24/2024
I	Dascu on observan	on and interview, the facility	K 0363	we respectfully request desk	02/24/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 8 of 20

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155786	B. W	ING _		02/08/2024	
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALLISONVILLE RD		
ΔΙΙΙΩΟΝ	IVILLE MEADOWS						
ALLISON	WILLE WIENDOWS			FISHERS, IN 46038			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f over 30 corridor doors had no			review in this matter. Thank y	ou	
	impediment to closing and latching into the door				for your consideration.		
		sist the passage of smoke.					
	This deficient pract	ice could affect 8 staff.					
					What corrective action(s) will l		
	Findings include:				accomplished for those reside		
					found to have been affected b	•	
		ons and interview during a			deficient practice; - no reside	ents	
	1	with the Maintenance Director			were affected by this alleged		
		en 11:20 a.m. and 1:30 p.m., the			deficient practice the		
		doors failed to latch positively			housekeeping closet, clean		
	into their respective door frames:				laundry and the medical recor		
	a) Clear Laundry near the Service Hall - the door				office doors have been correc	ted	
	1	floor as it attempted to close			and latch positively.		
	and failed to close a						
		Closet in the Kitchen Service			-		
	Corridor.						
		rds Office had a magnet over			How other residents having th	е	
		ed that "we have to do it so we			potential to be affected by the		
	can get in and out."				same deficient practice will be	:	
					identified and what corrective		
	_	reviewed with the Maintenance			action(s) will be taken;		
		of discovery and again with					
		Executive Director during the			All residents/staff have th		
	exit conference.				same potential to be affected	•	
					this alleged deficient practice.		
	3.1-19(b)				the housekeeping closet, clea		
					laundry and the medical recor		
					office doors have been correc	ted	
					and latch positively		
					IDT/Maintenance personnel h	ave	
					been educated by the Senior		
					Executive Director by 2/24/24		
					corridor doors latching positive	ely.	
					(see attachment A)		
			1		l .		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/24/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE	
AND I LAN	or connection	155786	B. WING		COMPLETED 02/08/2024	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS		FISHE	RS, IN 46038		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not receive the housekeeping closet does clean laundry door and the medical records office door he been corrected and latch positively IDT/ Maintenance personnel have been educated the Senior Executive Director 2/24/24 on corridor doors lated positively. (see attachment Almaintenance Director/designed will audit to ensure corridor delatch positively (see attachment C).	ges ecur; or, ave ed by by hing 0 ee poors	
				How the corrective action(s) a monitored to ensure the deficing practice will not recur, what quassurance program will be puplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director.  CQI tool identified as life.	ient uality it into h	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $W39W21 \quad \text{ Facility ID: } \quad 012466$ 

If continuation sheet

safety poc audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until

Page 10 of 20

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155786		(X2) MULTIPLE C A. BUILDING B. WING	<u></u>		
	PROVIDER OR SUPPLIER		10312	FADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD ERS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				compliance is achieved.  If Threshold of 100% is not met, an action plan will be developed to ensure compliant.  By what date the systemic changes will be completed;  Completion date: 2/24/24	ce.
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills				
Blag. 01	failed to conduct questimes under varying This deficient pract staff and visitors in Findings include:  Based on records result Maintenance Direct a.m. and 11:20 a.m. have fire drills at ur a. 3 of 4 First Shift a.m. b. 4 of 4 Second Sh 3:00 p.m. c. 4 of 4 Third Shift 5:00 a.m. Based on interview	eview and interview with the for on 02/08/24 between 9:30, the following shifts did not	K 0712	we respectfully request desk review in this matter. Thank yo for your consideration.  What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; - no reside were affected by this alleged deficient practice Fire drills conducted since 2/8/24 and ongoing to be completed with staggering times implemented from month to month.	e nts / the nts
	three shifts were no  The findings were r  Director at the time	t held at unexpected times.  eviewed with the Maintenance of discovery and again with Executive Director during the		same deficient practice will be identified and what corrective action(s) will be taken;  All residents/staff have th	е
	exit conference.  3.1-19(b)			same potential to be affected the this alleged deficient practiceFire drills conducted since 2/8	ру

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 11 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155786	A. BUILDING B. WING	01	COMPLETED 02/08/2024
	PROVIDER OR SUPPLIER		10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-51(c)			and ongoing to be completed staggering times from month to month Education provided to IDT/ Maintenance on fire drill policy and staggering of times (see attachment A).  What measures will be put interplace or what systemic chang will be made to ensure that the deficient practice does not reclifire drills conducted since 2/8/ and ongoing to be completed staggering times from month to month Education provided to IDT/Maintenance on fire drill pand staggering of times. (see attachment A) - Maintenance Director/designee to audit fire times to ensure times are staggered. (see attachment C	o the control of the
				How the corrective action(s) we monitored to ensure the defici practice will not recur, what que assurance program will be purplace;  Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being	ent uality t into

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 12 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155786	A. BUILDING 01  B. WING		COMPLETED 02/08/2024	
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0741 SS=E Bldg. 01	failed to ensure 1 of maintained by disposor noncombustible of cover devices. This 5 staff and residents  Findings include:  Based on observation tour of the facility won 02/08/24 between the smoking area in generator, there were disposed on the growsmoking area and exthe time of observat	on and interview; the facility 1 smoking areas were using cigarette butts in a metal container with self-closing deficient practice could affect in the smoking area.  ons and interview during a with the Maintenance Director in 11:20 a.m. and 1:30 p.m., in the rear of the facility near the e over 30 cigarette butts and in and around the cit door. Based on interview at tions, the MD concluded there tte butts on the ground in the	K 0741	every other month, and is overseen by the Executive Director.  CQI tool identified as life safety audits poc (see attachm C) will be completed weekly x weeks, monthly times 6 month and quarterly thereafter until compliance is achieved.  If Threshold of 100% is met, an action plan will be developed to ensure compliant.  By what date the systemic changes will be completed;  Completion date: 2/24/24  we respectfully request desk review in this matter. Thank you for your consideration.  What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; - no reside were affected by this alleged deficient practice The smoki area is clean and being maintained.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	4 is, not not noe.  4 02/24/2024  Du 02/24/2024  pe nts y the ents ng	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 13 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155786	B. WING 02/08/2024			/2024	
			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS				RS, IN 46038		
, recognitive mentions				1 IOI ILI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The findings were r	reviewed with the Maintenance			action(s) will be taken;		
	Director at the time	of discovery and again with					
	the MD and Senior	Executive Director during the			All residents/staff have th	ne	
	exit conference.				same potential to be affected	by	
					this alleged deficient practice.	-	
	3.1-19(b)				the smoking area is clean and		
					being maintained Education		
					provided to all staff by the Ser		
					Executive Director by 2/24/24	on	
					keeping the smoking area		
					maintained and disposing of		
					cigarette butts appropriately. (	see	
					attachment A)		
					What measures will be put into		
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec	ur;	
					Education provided by the		
					Senior Executive Director to a		
					staff by 2/24/24 on keeping the		
					smoking area maintained and		
					disposing of cigarette butts	<b>A</b> \	
					appropriately (see attachment		
					Maintenance Director/designe	е	
					will conduct audits to ensure		
					compliance of the smoking are	ea	
					(see attachment C).		
					How the corrective action(s) w		
					monitored to ensure the defici	ent	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet Page 14 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155786		A. BUILDING B. WING	01	COMPLETED 02/08/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				practice will not recur, what quassurance program will be put place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits (see attachment will be completed weekly x 4 weeks, monthly times 6 month and quarterly thereafter until compliance is achieved. If Threshold of 100% is r met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed; Completion date: 2/24/24	held  C)  is,  not  ce.			
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure 1 of Services Office were fixed wiring to prove high current draw. No unless specifically pand cables shall not	ent - Power Cords and on and interview, the facility 1 power strips in the Social e not used as a substitute for ide power equipment with a NFPA-70/2011, 400.8 state permitted in 400.7 flexible cords be used for (1) as a substitute is deficient practice could	K 0920	we respectfully request desk review in this matter. Thank yo for your consideration.  What corrective action(s) will be accomplished for those reside found to have been affected by	pe nts			
	affect up to 2 reside Findings include:			deficient practice; no resident were affected by this alleged deficient practice power strip use meet UL standards includ social services office with som	os in ing			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 15 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155786		A. BUILDING B. WING	01	COMPLETED 02/08/2024			
	PROVIDER OR SUPPLIER	<del></del>	STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
	tour of the facility we on 02/08/24 betwee refrigerator, microw power draw equipm supplied power by a Services office. Bas observation, the Ma acknowledged the power to high power to high power to Director at the time	with the Maintenance Director in 11:20 a.m. and 1:30 p.m., a wave and coffee machine (high ent) were plugged into and a power strip in the Social ed on interview at the time of intenance Director ower strip was supplying		appliances removed.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;  All residents/staff have the same potential to be affected this alleged deficient practice power strips in use meet UL standards including social services office with some appliances removed Educated provided to IDT/Maintenance. Social services by the Senior Executive Director by 2/24/24 power strip usage. (see attachment A).  What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not receive to the services of t	tion  to ges e cur; ces ctor age.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 16 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155786	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION  NG 01	(X3) DATE SURVEY  COMPLETED  02/08/2024	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD	02/00/2024	
	VILLE MEADOWS			312 ALLISONVILLE RD SHERS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG	G DEFICIENCY)	N (X5) SE COMPLETION DATE	
K 0923	NFPA 101			How the corrective action(s) monitored to ensure the def practice will not recur, what assurance program will be place;  Ongoing compliance withis corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director.  CQI tool identified as list safety audits poc (see attact C) will be completed weekly weeks, monthly times 6 monand quarterly thereafter untic compliance is achieved.  If Threshold of 100% is met, an action plan will be developed to ensure compliance will be completed; Completion date: 2/24/	ficient quality put into  with  fe hment v x 4 nths, iil s not ance.	
SS=E Bldg. 01	Storag Based on observati failed to ensure a n feet separated comb storage equipment rooms. NFPA 99, 1	Cylinder and Container on and interview, the facility ninimum distance of at least five custible materials from oxygen in 1 of 1 oxygen trans-filling 1.3.2.3 requires oxidizing gases ll be separated from	K 0923	we respectfully request des review in this matter. Thank for your consideration.  What corrective action(s) wi	you	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $W39W21 \quad \text{ Facility ID: } \quad 012466$ 

If continuation sheet Page 17 of 20

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155786	B. WING 02/08/2024			/2024	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ALLISONVILLE RD		
ALI ISON	IVILLE MEADOWS				RS, IN 46038		
			_		12, 10000		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)		DATE
	_	e of the following: (1) a			accomplished for those reside		
		of 20 feet. (2) a minimum			found to have been affected b	-	
		the required storage location			deficient practice; - no residen	ts	
		utomatic sprinkler system in			were affected by this alleged		
		FPA 13, Standard for the			deficient practice cardboard		
		nkler Systems. (3) Enclosed			boxes containing water have b	peen	
		oustible construction having a			removed from this area.		
	-	ection rating of ½ hour. This					
	-	ould affect 25 residents in one			-		
	smoke compartmen	ll.			Have alban maridants basis of	_	
	TP' 1' ' 1 1				How other residents having th		
	Findings include:  Based on observations and interview during a				potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
	-	with the Maintenance Director			action(s) will be taken;		
		en 11:20 a.m. and 1:30 p.m., 4			All: -! / +	_	
	-	tes containing water were			All residents/staff have the		
	-	lving in the Oxygen Storage			same potential to be affected	-	
		a. Based on interview at the , the Maintenance Supervisor			this alleged deficient practice.		
		materials in the form of			cardboard boxes containing w		
		ere stored within five feet of			have been removed from this	area.	
	liquid oxygen conta				- Education provided to IDT/Maintenance / nursing sta	ff by	
	ilquid oxygen conta	inicis.			the Senior Executive Director	-	
	The findings were r	reviewed with the Maintenance			2/24/24 on storage of combus	-	
	_	of discovery and again with			items in oxygen storage room.		
		Executive Director during the			(see attachment A).		
	exit conference.	Zaro zaroccor during the			(000 attaoriment A).		
	Jan Comprehense.						
	3.1-19(b)						
	>(0)						
					<u> </u>		
					What measures will be put into	)	
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec		
					- boxes removed from the oxy		
					storage room Education		
					I ======		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 18 of 20

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			<u>01</u>	COMPLETED		
155786		155786	B. WING			02/08/2024		
	NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIS DI ANI OE CORRECTIONI		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					provided to IDT/Maintenance/nursing staff the Senior Executive Director 2/24/24 on storage of combus items in oxygen storage room see attachment A) Audits to conducted by Maintenance Director/designee to ensure no combustible items are being stored in the oxygen storage room. (see attachment C)	by tible . ( be		
					How the corrective action(s) we monitored to ensure the deficinal practice will not recur, what quassurance program will be put place;  Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director.  CQI tool identified as life safety audits (see attachment will be completed weekly x 4 weeks, monthly times 6 month and quarterly thereafter until compliance is achieved.  If Threshold of 100% is met, an action plan will be developed to ensure compliant.  By what date the systemic changes will be completed;  Completion date: 2/24/24	ent uality t into  held  C) ns, not nce.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W39W21 Facility ID: 012466

If continuation sheet

Page 19 of 20

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155786	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/08/2024	
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)				DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W39W21 Facility ID: 012466 If continuation sheet Page 20 of 20